Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ODESSA REGIONAL MEDICAL CENTER 520 E 6TH STREET ODESSA TX 79763	MFDR Tracking #: M4-11-1913-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Not Paid"

Amount in Dispute: $2,148.70

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. Texas Mutual maintains its position that no payment is due for the reasons indicated on its EOBs."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
10/07/2010	Rev Code 250, CPT Codes 73030, 96372, 99284, J2175, J2405	N/A	$2,148.70	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §133.2(3) defines emergency, either medical or mental health emergency.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 11/30/2010:

   - CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment.
   - 242 – Not treating doctor approved treatment.
   - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2.
   - 724 – No additional payment after a reconsideration of services.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does emergency room treatment have to be approved by the treating doctor?
2. Does the submitted documentation support an emergency?

Findings

1. The respondent incorrectly denied the emergency room charges using denial codes "CAC-B7" and "242." Rule 180.22 states at (c) "The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency…"

2. The respondent has denied the emergency room treatment using denial code "899", stating that the documentation and file review did not support an emergency in accordance with Rule 133.2. According to Division Rule 133.2(3)(A) "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attend could reasonably be expected to result in: (i) placing the patient's health or bodily functions I serious jeopardy, or (ii) serious dysfunction of any body organ or part". Review of the submitted documentation by the requestor documents "had left shoulder surgery Sept 14th from trauma related accident. States left shoulder dislocated about 4 days ago while reaching for remote. Felt a pop. Deformity to left shoulder. Took with Tylenol with relief. Wearing shoulder immobilizer." Included in the nursing documentation for trauma assessment, the word "Trauma" was marked through and for the triage intervention the box stating "none" was checked.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	03/29/11 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.